

VACCINE ADMINISTRATION RECORD

Information collected on this form will be used to document authorization for receipt of vaccine(s). Information may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and the Social Security Number will be used by parent or guardian to access the Wisconsin Immunization Registry.

Patient's Name (Last, First, Middle Initial)				Mother's Maiden Name (Last, First, Middle Initial)			
Address (Street/Road/POBox)						Home Telephone Number ()	
City		County		State		Zip Code	
Social Security Number		Date of Birth (mm/dd/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Ethnicity (Check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Race (Check one) <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> Other							
Eligibility Status (Check all that apply) This section must be completed.				<input type="checkbox"/> Native American <input type="checkbox"/> Badger Care <input type="checkbox"/> Insured, Vaccines Covered <input type="checkbox"/> Medicaid Eligible <input type="checkbox"/> No Health Insurance <input type="checkbox"/> Insured, Vaccines Not Covered			
Name of Physician		Name of Insurance Provider			Name of School or Day Care (if applicable)		
Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial)					Relationship to Patient		
Okay to share immunization data with WIR? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is reminder or recall contact allowed? <input type="checkbox"/> Yes <input type="checkbox"/> No			Would you like reminder/recall sent to you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
I have been given a copy and have read, or have had explained to me, information about the disease(s) and vaccine(s) to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.							
Wisconsin Medicaid restricts billing recipients for any covered service(s). I understand that if I am a Medicaid/BadgerCare recipient I cannot be charged an administration fee or asked for any type of donation for the administration of any vaccine that is being provided.							
SIGNATURE - Person to receive vaccine or person authorized to sign on the patient's behalf.						Date Signed	

FOR OFFICE USE

* RV=R Vastus Lateralis, LV=L Vastus Lateralis, RD=R Deltoid, LD=L Subcutaneous injections are administered in the muscle "area".

Vaccine	Route	Site Admin*	Dose Number	Manufacturer	Lot Number	Exp Date	CDC Form Date
DTaP	IM	RV LV RD LD	1 2 3 4 5	GSK			05/17/07
DTaP-IPV Combined (Kinrix)	IM	RV LV RD LD	1 2 3 4	GSK			Use dates from DTaP, Polio
DTaP-IPV-Hep B Combined (Pediarix)	IM	RV LV RD LD	1 2 3 4	GSK			Use dates from DTaP, HepB, Polio
DTaP-IPV-Hib Combined (Pentacel)	IM	RV LV RD LD	1 2 3 4	SP			Use dates from DTaP, Hib, Polio
Hepatitis A	IM	RV LV RD LD	1 2	GSK			03/21/06
Hepatitis B	IM	RV LV RD LD	1 2 3	GSK			7/18/07
Hib	IM	RV LV RD LD	1 2 3 4	Merck			12/16/98
HPV (Human Papillomavirus)	IM	RV LV RD LD	1 2 3	Merck			02/02/07
Influenza	IM	RV LV RD LD	1 2				Use latest VIS
Meningococcal Conjugate (MVC4)	IM	RV LV RD LD	1	SP			1/28/08
MMR	SQ	RV LV RD LD	1 2	Merck			3/13/08
Pneumococcal Conjugate (PCV7) (Prev nar)	IM	RV LV RD LD	1 2 3 4	Wyeth			09/30/02
Polio	IM or SQ	RV LV RD LD	1 2 3 4	SP			01/01/00
Rotavirus	Oral	RV LV RD LD	1 2 3	Merck			08/28/08
Td	IM	RV LV RD LD	1 2 3 4 5	SP			11/18/08
Tdap (Adacel / Boostrix)	IM	RV LV RD LD	1	SP / GSK			11/18/08
Varicella (Chickenpox)	SQ	RV LV RD LD	1 2	Merck			3/13/08
Other		RV LV RD LD					

Signature & Title - Person Administering Vaccine		Date Vaccine Administered	
Staff Nurse RN BSN			